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INTER-AMERICAN DEVELOPMENT BANK
MULTILATERAL INVESTMENT FUND

BOLIVIA

HEALTH MICROINSURANCE IN BOLIVIA

(BO-M1055)

DONORS MEMORANDUM

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HEALTH MICROINSURANCE IN BOLIVIA (BO-M1055)

In Bolivia, the supply of health services for the low-income population is limited. Economic statistics show that in 2010 only 31% of the population had access to health insurance, primarily because Bolivian social security covers wage earners and excludes families that earn their living through self-employment or agricultural activity. It has also been shown that low-income households resort to loans and to selling their assets to cover emergency health expenditures.

In order to reduce low-income households' financial vulnerability to catastrophic health events (one that requires 10% or more of the household's monthly income), the project will design, test, implement, and make widely available an insurance financial product consisting of a prepaid card that covers a basic health plan and health microinsurance issued and underwritten by an insurance company.

At the impact level, the objective is to reduce the out-of-pocket health expenditures of low-income households that purchase and use health microinsurance, in order to contribute directly to maintaining the insured population's income levels in the event of a health emergency. At the outcome level, the project intends to implement an interagency model that links health care supply and demand by developing an insurance financial product that meets the needs of the low-income population in urban and periurban areas of La Paz and El Alto, Quillacollo, Cochabamba, Ypacani, Montero, and Santa Cruz de la Sierra. This product is expected to directly benefit some 60,000 low-income people, 60% of whom are expected to be women and children, through the sale of 20,000 insurance policies.

It should be noted that the executing agency, PROCOSI, has devoted more than three years to studying the problem and defining the possible institutional framework. It has also conducted some market and demand studies in low-income communities.

To achieve these objectives, the project involves a partnership between the executing agency (PROCOSI, a network of health care providers), an insurance company, and a microfinance institution. Under the model, the aforementioned insurance financial product will be sold to the microfinance institution's clients. The prepaid card will be backed by the health service providers and an insurance company will underwrite the risk of the health emergencies covered by the policy. The project also includes raising the awareness of and educating the staff of the health service providers and the microfinance institution, as well as their clients, about health and insurance matters.

The project will help bridge knowledge gaps in the microinsurance agenda, particularly with regard to: (i) the economic impact of microinsurance on clients; and (ii) the impact of health microinsurance on the low-income population's access to and use of preventive health services.

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AVAILABLE IN THE DOCUMENTS SECTION OF THE MIF'S PROJECT INFORMATION SYSTEM

Annex IV	Detailed budget IDBDOCS-#37967278- Detailed budget
Annex V	Preliminary list of milestones IDBDOCS-#37967299- Preliminary project milestones
Annex VI	Diagnostic of Executing Agency Needs IDBDOCS-#37967275-Needs assessment
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ABBREVIATIONS

CEMSE	Centro de Multiservicios Educativos [Educational Multiservices Center]
CIES	Centro de Investigación, Educación y Servicios [Research, Education and Service Center]
CSRA	Consejo de Salud Rural Andino [Andean Rural Health Council]
DFI	Development finance institution
FINRURAL	Asociación de Instituciones Financieras de Desarrollo [Association of Development Finance Institutions]
ILO	International Labor Organization
INE	Instituto Nacional de Estadísticas [National Statistics Institute]
NGO	Nongovernmental organization
PROCOSI	Programa de Coordinación en Salud Integral [Comprehensive Health Coordination Program]
PSR	Project status report
SDC	Swiss Development Corporation
SPAM	Seguro para el Adulto Mayor [Senior citizen insurance]
SUMI	Seguro Universal Materno Infantil [Universal Mother and Child Insurance]
WHO	World Health Organization

BOLIVIA
HEALTH MICROINSURANCE IN BOLIVIA
(BO-M1055)

EXECUTIVE SUMMARY

Country:	Bolivia		
Executing agency:	PROCOSI		
Area of access:	Access to finance		
Agenda:	Microinsurance		
Direct Beneficiaries:	The project intends to directly benefit a total of 60,000 low-income people, ¹ 60% of whom are expected to be women and children. It will also benefit the financial institution CRECER and four health care providers belonging to the PROCOSI network.		
Indirect beneficiaries:	40,000 low-income people.		
Financing:	Technical cooperation	US\$ 900,000	68.9%
	Local counterpart:	US\$ 408,340	31.1%
	PROJECT TOTAL:	US\$1,308,340	100.00%
Execution timetable:	Execution period:	42 months	
	Disbursement period:	48 months	
Special contractual conditions:	The following will be conditions precedent to the first disbursement: (i) approval by the board of directors of the project's Operating Regulations; and (ii) selection of the project coordinator.		
Environmental and social review:	The project was submitted to the ESR review process, approved, and classified as a category "C" operation		
Disbursing unit:	COF/CBO		

¹ People whose daily incomes range between US\$4 and US\$10, also considered an at-risk population.

I. DIAGNOSTIC ASSESSMENT OF THE PROBLEM TO BE ADDRESSED

A. Main characteristics of Bolivia's health system² and insurance market

- 1.1 The Bolivian health system, under the leadership of the Ministry of Health and Sports, is charged with setting policy and regulating the sector to ensure effective delivery of services. It is comprised of two sectors: public and private. The public sector consists of the long- and short-term social security subsectors. Long-term social security is managed by the Pension Fund Administrators. Short-term social security, better known as *cajas de salud* [health care funds],³ includes: the Caja Nacional de Salud [National Health Care Fund], which covers more than 79% of the insured population; five additional public *cajas*; one private *caja*; the Military Social Security Corporation (COSSMIL), and eight university insurance programs. Each *caja* has a network of health care providers. The public sector offers primary, secondary, and tertiary health care, as well as emergency services, through the municipalities. It also offers Universal Mother and Child Insurance (SUMI) and Senior Citizen Insurance (SPAM). For its part, the private sector health system is comprised of private insurance companies that receive insurance premiums from the non-poor population, and church programs, nongovernmental organizations (NGOs), and other private providers financed mainly by external donations. The entire sector is overseen by the National Health Insurance Institute.
- 1.2 In theory, social security covers 32.6%⁴ of the population through short-term social security (*cajas*), whose members are all employees with formal jobs and their dependents. This means that independent microentrepreneurs, self-employed people working without a contract, people working in family businesses or informal trade, etc., are not covered by social security. An additional 20.6% of the population is covered by SUMI, SPAM, and other public insurance programs, which means that, in theory, 52.9% of the population is covered. An analysis based on family incomes revealed 16.8% coverage in decile 1 (poorest) and 48.8% coverage in decile 10. Nevertheless, only 31% of the population indicated

² Several studies were taken into account in writing this chapter, including: the IDB sector note on the health sector (<http://idbdocs.iadb.org/wsdocs/getdocument.aspx?docnum=36695299>); an article on Bolivia's health system published in *Sistema de Salud en México*, volume 53, supplement 2 of 2011, by Carmen Ledo and René Soria; "El sistema de salud boliviano" by Sydney Edson Morales Medina, mimeo; WHO studies on exclusion in health care; statistics from the National Statistics Institute (INE) and the Institute of Partnership and Social Economy (INAES); and, mainly, "Cobertura poblacional de seguros de salud en Bolivia," by the Ministry of Health and Sports, September 2011. Bolivia.

³ *Cajas de salud* (health care funds) are legally established, nonprofit institutions characterized by autonomous management and independent assets, with responsibility for managing, applying, and implementing the social security system. Each *caja* is managed autonomously and collects its fees, administers its resources in a centralized manner, and provides health care usually with its own infrastructure and own resources, although the strategy of care varies widely among the different *cajas*. The health care services offered are spelled out explicitly in the legislation that governs health care activity. From: Maceira, Daniel, *Organización y Funcionamiento de las Cajas de Salud en Bolivia*, 2002.

⁴ Based on the population in 2010 of 10,426,154 people, according to INE.

that it uses health insurance. Of the portion of the Bolivian population that is not covered, an estimated 30% has access to health care services provided by traditional medicine,⁵ paid for out-of-pocket.

- 1.3 **Analysis of the insurance sector in Bolivia.** Insurance Law 1883, which entered into force in June 1998, regulates and governs insurance and reinsurance activity in Bolivia, determines the rights and duties of insurance agencies, and establishes the principles of “equity” and “legal certainty.” Among other things, the law establishes the solvency ratio for calculating assets; minimum capital levels for insurers, reinsurers, and intermediaries; and technical reserve requirements. It also sets new standards for investments and establishes two types of insurance companies: general insurance and insurance for individuals. The Superintendency’s protection of the interests of the insured is provided for under this law, which establishes that all insured have the right to clear, truthful, and sufficient information on the products and services offered by insurance companies.⁶
- 1.4 **Market size.** As of July 2013, there were 13 insurance companies registered with the Pensions and Insurance Supervisory Authority, seven offering general insurance and bonding, and six offering life insurance. Although the market is small and market penetration is low, it has shown sustained growth in recent years, driven primarily by general insurance. At the close of 2012, the overall market had grown by 19.73%, with net premiums totaling US\$316.8 million. General insurance premiums reached US\$201.9 million (+19.02% over 2011), with most sales in that category being for fire insurance (24%), personal accident insurance (10.68%), and automobile insurance (25.6%). General insurance companies are authorized to manage health and illness insurance. The three companies that participated in this market (Alianza, Ciacruz, and BISA) generated US\$13.9 million in premiums, that is, 6.9% of the general insurance market. For its part, insurance for individuals grew by 23.26%, generating US\$80.9 million, primarily in the categories of mortgage title insurance (41.3%) and individual life insurance (25.6%). Health and illness insurance was handled by only three companies (Alianza, BUPA, and Nacional Vida) and generated US\$5.8 million, accounting for 7.2% of the individual insurance market.
- 1.5 **Market penetration and density.** Average per capita spending on premiums in 2012 was US\$31.68. (The lowest penetration registered in Swiss Re’s SIGMA report is Guatemala, at US\$32.20 per capita.) This contrasts sharply with penetration in North America (US\$3,996 per capita), and even with the very low density for Latin America and the Caribbean as a whole (US\$281.90 per capita).

⁵ Traditional medicine is an extremely diverse topic given the multicultural context of the Plurinational State of Bolivia. Each indigenous group (36 in the country) has its own concept of health and disease, which results in a broad range of traditional medicines. The common factor shared by these traditional medicines is the connection between diseases of the body and diseases of the mind. From the website of the Pan American Health Organization (PAHO).

⁶ Asociación Boliviana de Aseguradores [Bolivian Association of Insurance Companies]. Website.

In Bolivia, market penetration, that is, the ratio of premiums generated to gross domestic product, is 1.29%, which is lower than the average of 1.72% for Latin America and the Caribbean.

- 1.6 **The problem.** The access of Bolivia's low-income population to and use of health services and insurance are limited. Regarding access to health care, Bolivia is one of the countries in the region with the lowest number of physicians per capita, with a ratio of 1.22 physicians per 10,000 inhabitants. Other factors that limit health care access include geographical and economic barriers, cultural traditions, and informal employment. With regard to geographical barriers, Bolivia's topography hinders access to health services in periurban and rural areas. With regard to economic barriers, the total cost (direct and transactional) of obtaining health services generally exceeds the economic capacity of the excluded population. Cultural factors include the fact that not all health care centers have personnel who can speak the different languages of the indigenous populations and, although efforts are currently under way to formalize traditional medicine systems, in general the services offered today do not provide for the uses and customs of indigenous people (52.3% of the population). Lastly, as already noted in paragraph 1.2 above, informal employment has a direct effect.
- 1.7 With regard to access to microinsurance, a MIF-financed study in 2012 showed that only 7.23% of the population had access to conventional individual microinsurance.⁷ In particular, according to an IDB technical note prepared in 2011, 69% of the population did not have health insurance.
- 1.8 Not having health insurance can represent an economic catastrophe for at-risk and low-income people. According to the World Health Organization (WHO), health expenditures can be seen as a catastrophic event⁸ when a household must reduce its basic expenditures for a given period of time in order to cope with the medical expenditures of one or more of the family members. Although this situation affects men and women alike, women are considered to be at greater risk because: (i) they are the principal caregivers or persons responsible for sick family members; (ii) they have different medical needs than men that require preventive care and monitoring (pregnancy, cervical cancer, etc.); and (iii) they are the first to be affected by illness in the home (less food, less income for the household, etc.) if there is a drop in household income. In general, early detection and access to preventive health can save the lives of low-income people.
- 1.9 It is worth underscoring that a lack of health protection means that families not only experience the illness but also the attendant economic shock, which, in some cases, can mean that catastrophic expenditures (10% of household income) are incurred. The great proportion of out-of-pocket expenditures on health (83% of health spending in the private sector) reveals an uncompetitive system where a

⁷ The Landscape of Microinsurance in Latin America and the Caribbean. McCord et al, 2012

⁸ According to WHO, a catastrophic event is one that absorbs 40% of the household's ability to pay; this refers to the income available once basic subsistence needs (housing, food, clothing) have been covered.

“risk pool” does not necessarily exist, making payments more costly than if prepayment arrangements and insurance were available.⁹

B. Timeliness

1.10 Health microinsurance. Health microinsurance is a means for people who normally do not have access to quality medical services to gain access to medical services. “Research indicates that 26% of households in low- and middle-income countries resort to borrowing and selling assets to cover healthcare expenses, suggesting that there is a huge gap in health care financing.”¹⁰ One of the characteristics of the microinsurance market is high demand for health insurance products and an excessive supply of life insurance products. This can be explained by the fact that designing health care products is more complex than designing other types of insurance. Traditional health insurance covers high risks that are of unpredictable frequency and require high-cost, intensive services. However, given the circumstances of poor beneficiaries, health microinsurance should try to insure high frequency, predictable risks that require relatively low-cost services. This makes them inherently more expensive and difficult to design. Lastly, health microinsurance should supplement social security programs, helping to close the gap in the overall social security system, a gap that mainly affects the poor and informal workers.

1.11 Lessons learned from implementing health microinsurance. In addition to the difficulty of designing microinsurance products, some additional problems include: (i) low rates of purchase, (ii) high incidence of claims, and (iii) low rates of renewal. The low purchase and renewal rates are attributed to a lack of familiarity with insurance and with financial strategies for managing risk. Milliman’s research¹¹ found the following causes of problems associated with health microinsurance projects: (i) the design does not reflect the real needs of potential clients; (ii) the characteristics of demand are not taken into account (for example, global one-time payments or time requirements); and (iii) lower-income people do not understand insurance sufficiently. Indeed, some think that, if they were not sick during the year, they have been cheated by the insurance company, or similarly, that they paid a premium and received nothing in return. Nor do they grasp copayments, exclusions, coverage, etc. The idea that insurance is a fraud spreads quickly through the grapevine, and people are not willing to give up their limited surplus liquidity to pay for a product that has no value.

⁹ Household Catastrophic Health Expenditure: A Comparative Study of 12 Latin American and Caribbean Countries. Knaul et al, 2011.

¹⁰ Innovations and barriers in health microinsurance. ILO, 2010

¹¹ “Health Microinsurance: Health Care and Insurance and Incidence Rate Questionnaire. A Tool for Technical Advisors.” February, 2010.

- 1.12 Of the 117 cases studied by the MicroInsurance Network working group,¹² only nine are in the region and have not yet yielded conclusions. The observations of the Asian and African cases led to an initial assessment similar to that reached by the Comprehensive Health Coordination Program (PROCOSI) and its affiliates. In general: (i) low-income people do not have enough time or resources to go to a health center; (ii) low-income people prefer traditional home remedies over medical care provided by strangers; and (iii) if potential beneficiaries are offered the possibility of purchasing a prepaid health care service and supplementary medical microinsurance, a significant reduction can be achieved in the cost of health care for some diseases.
- 1.13 **Proposed project.** Taking into account the lessons learned in other regions and an initial study conducted by the executing agency (PROCOSI) (see paragraph 5.1), the project intends to design, test, implement, and make widely accessible an insurance financial product made up of a prepaid card that covers a basic health plan and health microinsurance issued and underwritten by an insurance company.¹³ The prepaid part will cover “high-probability, low-cost” events such as preventive health services or services that reduce the severity of disease (obstetrics, pediatrics, gynecology, dentistry, radiology, nursing, ultrasound, pharmacy, clinical laboratory, emergencies, and general medicine). For its part, the health insurance policy issued by the insurance company will cover “low-probability, high-cost” events. This dual product (prepaid card plus microinsurance) will provide the population not covered by social security with benefits that supplement those afforded by the state, which are in the process of being implemented through universal social security. Moreover, having a product that includes direct, short-term benefits (i.e. of high value to clients) will help overcome the cultural problem of unfamiliarity with and distrust of insurance.
- 1.14 It should be noted that the executing agency, PROCOSI, has invested more than three years in studying the problem and defining a possible institutional framework. It has also conducted some market and demand studies in low-income communities.

C. Project beneficiaries and gender characteristics

- 1.15 At the outcome level, the project intends to implement an interagency model that links health care supply with demand, by developing an insurance financial product that meets the needs of low-income people in the urban and periurban areas of La Paz and El Alto, Quillacollo, Cochabamba, Yapacani, Montero, and Santa Cruz de la Sierra.¹⁴ This product is expected to directly benefit 60,000

¹² MicroInsurance Network is the only global platform that brings together all those involved in the microinsurance sector: regulators, insurance companies, distribution channels, donors, academia, and consultants. It is a nonprofit agency based in Luxembourg.

¹³ The prepaid health services covered, and the policy’s cost and coverage, will be determined in Component I of the project.

¹⁴ <http://geocommons.com/maps/168767>

low-income people, 60% of whom are expected to be women and children, through the sale of 20,000 insurance policies. These people are members of families characterized by low levels of education, who are “self-employed” in commerce and services. Initially, the project will cover the needs of the microfinance institution CRECER,¹⁵ which is the largest of the member organizations of FINRURAL¹⁶ [Association of Development Finance Institutions], and of the clients of the four health centers¹⁷ that are members of PROCOSI and have joined the project.

- 1.16 **Associated financial institutions.** CRECER has more than 135,000 clients, 84% of whom are women. Their basic characteristics are: 3% are illiterate, 31% have primary education, 24% have secondary education, 24% are high school graduates, 6% have technical training, and 11% have university education. Of these women, 78% are of childbearing age (ages 21 to 50); 6% are under age 20, and 16% are over age 50; 52% live in rural areas, and 82.3% are connected through community banks. The average loan size is US\$1,016.57. As part of the additional services CRECER offers its women clients, 13.6% have received preventive cancer exams. In addition, it has developed a new product, a “credit for health,” which to date does not represent a significant percentage. The characteristics of male and female health center clients are very similar. The four health centers combined serve nearly one million women and children.
- 1.17 **Associated health care centers.** **PROSALUD** is a nonprofit organization that offers health services to the low-income population of Bolivia, with 24 health centers and six second-level clinics in the departments of La Paz, El Alto, Beni, Oruro, Cochabamba, Tarija, and Santa Cruz, where they serve nearly half a million people annually. The **Centro de Investigación, Educación y Servicios** [Research, Education, and Services Center] (**CIES**) is a private, nonprofit social development organization that has been serving the at-risk rural and periurban population since 1994. CIES works to improve reproductive health and family planning, with a focus on providing effective treatment for women. In 2012, it served a total of 355,300 people, 76% of them women, through a network of 12 health centers in the municipios of Cobija, Umosas, Trinidad, Cochabamba, Montero, Santa Cruz, Tarija, Sucre, Potosí, Oruro, El Alto, and La Paz. The **Centro de Multiservicios Educativos** [Educational Multiservices Center] (**CEMSE**) is a nonprofit organization with three health care centers in La Paz and El Alto. In 2012 it served 10,800 patients, 60% of them women, providing general medicine, pediatrics, gynecology, dentistry, nursing, pharmacy, X-rays, and clinical laboratory. The **Consejo de Salud Rural Andino** [Andean Rural Health Council] (**CSRA**) is a nonprofit organization that offers child health services in periurban and rural areas, where it has successfully implemented several child

¹⁵ The microfinance institutions that are members of FINRURAL are called development finance institutions.

¹⁶ A network of microfinance institutions that serve the rural sector and are regulated and supervised as development finance institutions.

¹⁷ Prosalud, CIES, CEMSE, and CSRA.

health programs with international cooperation agencies, to the benefit of 27,000 school-age children (ages 5 to 14) in the Montero region and indigenous communities. They receive eye exams and some get the relevant treatment including, in some cases, free eye surgery.

D. Contribution to the MIF mandate, Access Framework, and IDB strategy

- 1.18 This project is aligned with the MIF's mission because it focuses on reducing poverty, improving health conditions for the poor and low-income population, and offering viable economic alternatives for reducing their out-of-pocket expenses. It also contributes to private sector development since it strengthens health care service providers and facilitates the involvement of the insurance sector so that it can assume health risks.
- 1.19 Connection with the Agenda. The project is aligned with the MIF's microinsurance agenda, the objective of which is to increase the number of providers that sustainably offer microinsurance services to meet the needs of low-income populations in Latin America and the Caribbean. This project will help bridge the knowledge gaps in the microinsurance agenda related to: (i) the economic impact of health microinsurance on clients, and (ii) the impact of health microinsurance on access to and use of preventive health services among the low-income population.
- 1.20 Collaboration with the IDB Group. This project supplements the operation "Project to Support Improved Access to Health Care Services in Bolivia" (BO-T1164), which was approved in May 2012 and is currently under way; its objective is to strengthen the operation of the health networks in Potosí and in the city of El Alto. The project is also consistent with the IDB's 2011-2015 Country Strategy with Bolivia, which points to the need for "a narrowing of quantitative and qualitative gaps in the supply of health services in the framework of a long-term policy, particularly in rural areas; a reduction of maternal-infant mortality and chronic malnutrition; and a strengthening of the sector's institutions and management capacity."¹⁸ Lastly, the project is in alignment with the conclusions of the IDB's technical note on the health sector in Bolivia (2012), which underscores the importance and necessity of improving access to health care for the most at-risk population, to wit, the poor, rural inhabitants, and indigenous populations.

II. PROJECT OBJECTIVES AND COMPONENTS

A. Objectives

- 2.1 At the impact level, the objective is to contribute to enabling the low-income population of Bolivia to maintain a stable flow of income and consumption in the event of possible health problems. At the outcome level, the project intends to

¹⁸ IDB: Country Strategy with Bolivia (2011-2015). Revised version

implement an interagency model that links health care supply and demand by developing an insurance financial product that meets the needs of the low-income population in the urban and periurban areas of La Paz and El Alto, Quillacollo, Cochabamba, Yapacani, Montero, and Santa Cruz de la Sierra. This product is expected to directly benefit 60,000 low-income people, 60% of whom are expected to be women and children, through the sale of 20,000 insurance policies.

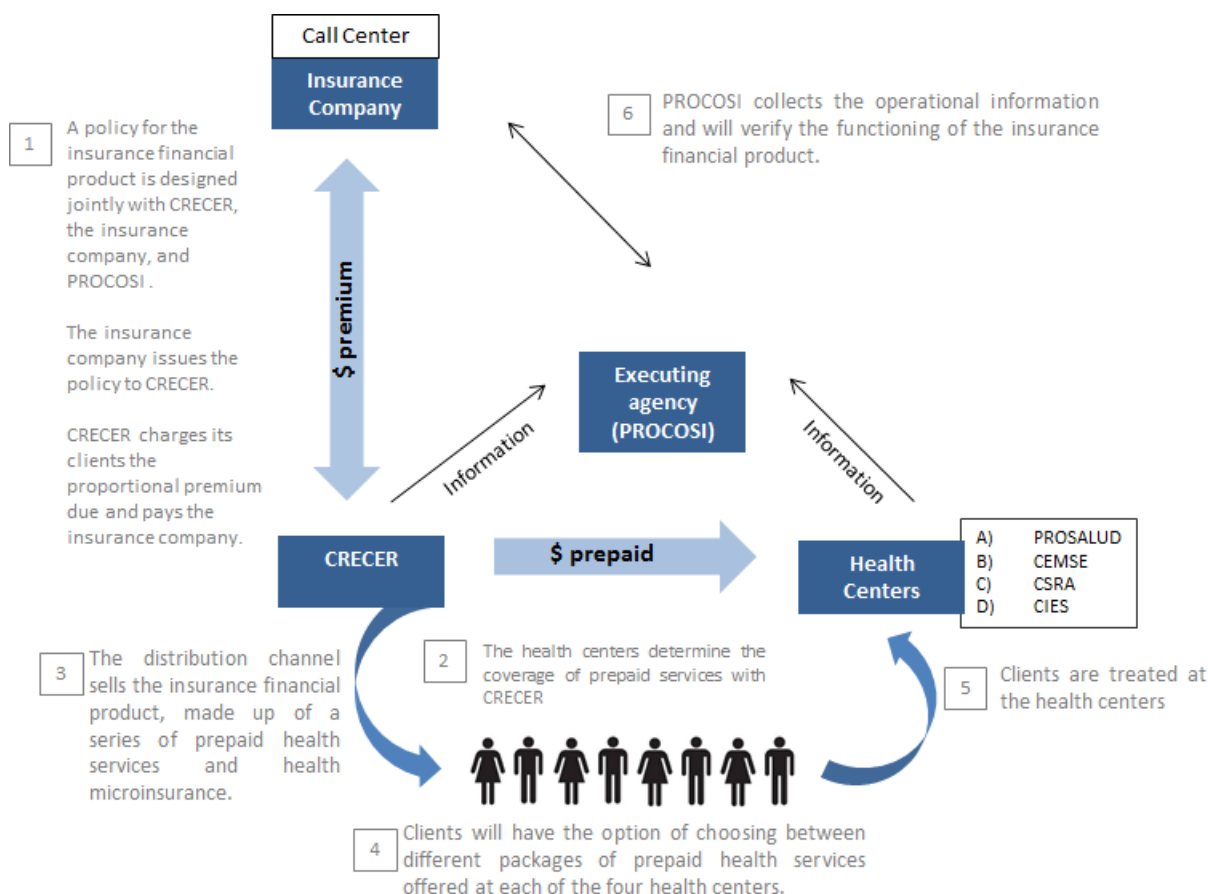
B. Description of the model/solution/intervention

- 2.2 The project will test a model that increases the low-income population's access to and use of health care services, by designing, testing, implementing, and making widely available an insurance financial product consisting of a prepaid card with a basic health plan and health microinsurance issued and underwritten by an insurance company.¹⁹ The prepaid card will cover "high probability, low-cost" events, that is, health services that help prevent disease or reduce their severity. The insurance policy will cover "low-probability, high-cost" events.
- 2.3 Since the package of health services prepaid by the beneficiary will focus primarily on preventive health, the project will include a policy issued by an insurance company that will include coverage of basic care for more costly treatments/events (i.e., appendectomy, gall bladder surgery, a fixed amount for the first diagnosis of a serious disease such as diabetes, cancer, etc.). The coverage of the two services will be determined in Component I and will take into account morbidity in the region, gender-specific needs, and, in general, the needs of potential clients and their ability to pay an amount that covers the prepaid health care package and the insurance policy for more serious health emergencies. The insurance premium will take into account that the use of the prepaid services will inherently reduce the health insurance risk.
- 2.4 The health microinsurance product will be jointly designed by the PROCOSI network, the insurance company (Alianza), the four health centers,²⁰ and CRECER. The design will take into account actual demand from women clients and their families, as well as their ability to pay. The services offered by the health centers for the prepaid health care and possible hospitalization services should, at least, ensure significant value for clients, which will be reflected in: (i) a suitable policy renewal rate by beneficiaries (at least 50%); (ii) an appropriate claims rate of tangible value to beneficiaries (the claims rate of the prepaid card should be close to 100%; that of the microinsurance, at least 35%); (iii) in other words, what is needed is a cost structure that enables institutions participating in the value chain to offer their services to end beneficiaries at an appropriate cost, which, in turn, meets their operational needs.

¹⁹ The supply of prepaid health services, the cost of the policy, and its coverage will be defined in Component I of the project.

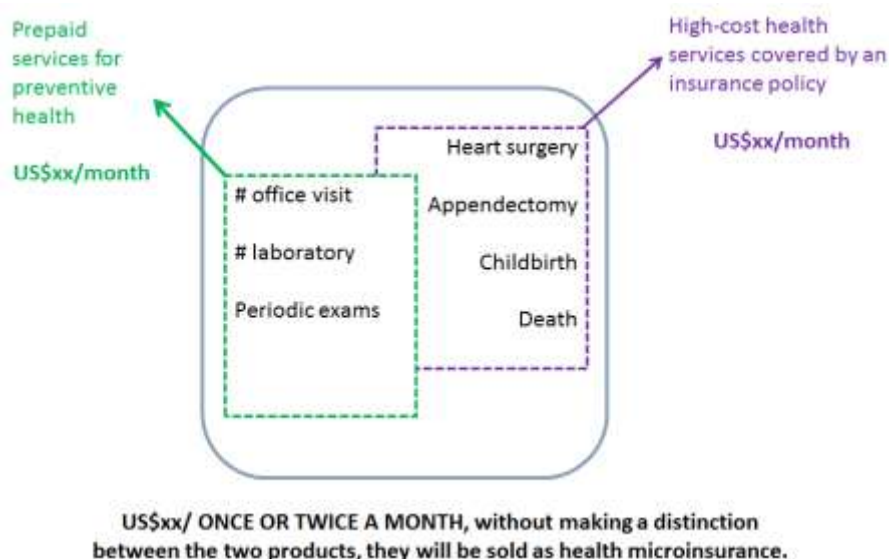
²⁰ PROSALUD, CIES, CEMSE, CSRA.

Figure I. Business model



2.5 The parties directly involved in the project will design an insurance financial product that takes into account the clients' needs and financial capacity. As indicated in Figure II below, the product will comprise a prepaid medical service and an insurance policy. The prepaid service will be designed by the participating health centers, in accordance with their technical and human resources capacity. In other words, CRECER's clients will have the option of selecting the product most suited to their needs, based on the supply offered by the health centers. The insurance premium will be paid for at CRECER, which will divide the amount received among the prepaid service, which will be sent to the health centers, and the health insurance, which will be sent to Alianza insurance company. For their part, clients will request the services covered by the insurance financial product at the health centers. Should the clients of the health centers wish to purchase the product, the relevant health center will send them to CRECER, which will have access to Alianza's information system.

Figure II. Structure of the product



C. Components

Component I: Design of a prepaid health care and health microinsurance model (MIF: US\$222,000; counterpart: US\$106,100)

- 2.6 The objective of this component is to design, test, implement, and make widely available an insurance financial product consisting of a prepaid card for a basic health plan and health microinsurance issued and underwritten by an insurance company.²¹ To this end, it will be necessary: (i) to validate PROCOSI's initial assessment of current demand for health services among the low-income population of Bolivia against potential beneficiaries' real ability to pay; (ii) to assess: (a) the ability of the health centers to meet demand from the population, including the capacity of the insurance company's call center to answer questions, make sales, and process claims; and (b) beneficiaries' ability to pay; (iii) to perform actuarial studies and financial viability studies to enable the insurance company and the project's executing agency to design the product such that it offers high value added for beneficiaries and generates profits for the institutions involved in its development.
- 2.7 The activities of this component are: (i) legal advisory services for implementing the product; (ii) assessment of the different financial scenarios for the business model; (iii) a study of potential clients' risk profile, ability to pay, and morbidity profile; (iv) analysis of the supply of health services; (v) determination of logistics for providing health services to beneficiaries; (vi) actuarial consulting services to

²¹ The services to be offered through the prepaid card, the specific coverage, and the microinsurance premium will be precisely defined as part of the project's Component I.

develop and define the product's attributes; (vii) international advisor with expertise in health microinsurance to provide advisory services on microinsurance to the executing agency; (viii) processes for connecting and linking the information systems of the value chain (insurance company, distribution channel, health care providers);²² and (ix) development of a project monitoring and control system.

Component II: Implementation and strengthening of microinsurance management (MIF: US\$320,660; counterpart: US\$203,640)

- 2.8 The objective of this component is to strengthen the capacity of the distribution channels (CRECER and health centers) for providing effective services to beneficiaries. Experience with the development of health microinsurance²³ has shown that health care providers' capacity must be strengthened, especially if they serve underserved populations, and that strengthening efforts should focus on improving the operational efficiency of: (i) operating systems and processes, with special emphasis on customer service; (ii) information management, including training on the confidentiality of information; (iii) fraud prevention; and (iv) pricing of products and services. Although CRECER already offers microinsurance, its employees and credit officers also need special training to familiarize them with the product to be offered as well as the processes to be implemented for selling the policies and managing insurance claims.
- 2.9 The activities of this component are: (i) strengthening of management at the health centers; (ii) development of procedures manuals; (iii) customer service training for health center staff (including staff at the call center provided by the Alianza insurance company); (iv) consulting services to develop the microinsurance training program; (v) implementation of microinsurance management tools; and (vi) support, control, and monitoring on site for product marketing and service.

Component III: Consumer protection and financial and health education (MIF: US\$75,500; counterpart: US\$33,500)

- 2.10 The objectives of this component are for beneficiaries to become familiar with and adopt the health insurance financial product as a mechanism to mitigate the risks of extraordinary health expenses; and for beneficiaries to use preventive medical office visits and health exams to avoid developing more serious diseases, or diseases that require more costly treatment.
- 2.11 The activities of the component are to: (i) review the various existing financial training methodologies and adapt the one most suited to local conditions to the

²² This activity consists of adapting an interface of Alianza's technological platform to link it to the information systems of CRECER, PROCOSI, and the health care centers.

²³ See the microinsurance portal of the Microinsurance Innovation Facility.

specific product and to the characteristics of demand (including, for example, gender-specific training); (ii) review and adapt the training tools and materials; (iii) design and implement a train-the-trainers program and an education program for beneficiaries; and (iv) design and implement a training program for the staff of CRECER, the insurance company, and the four health centers.

Component IV: Knowledge development and implementation of a communication strategy (MIF: US\$48,500)

- 2.12 The objective of this component is to collect the knowledge and disseminate the lessons learned and the best practices generated by implementing the new insurance financial product.
- 2.13 The following audiences will be targeted for disseminating and communicating the knowledge and experiences produced through the project: (i) microfinance institutions interested in adding health microinsurance to their menu of services; (ii) insurance companies in Latin America and the Caribbean interested in offering health insurance to low-income populations; (iii) regulatory authorities in the insurance and health sectors; (iv) civil society (nongovernmental organizations) that offer health and welfare services to the poor and to low-income populations; and (v) project beneficiaries.
- 2.14 In order to meet the knowledge needs of these audiences, the following knowledge products will be developed: (i) a project fact sheet, to be distributed publicly once a year, that will cover partial results of implementation, the main challenges, and how they were addressed; (ii) a methodological guide, to be prepared at the end of the intervention, which will summarize the main characteristics of the business model; and (iii) organization of and participation in events to disseminate the project's lessons learned (2016 FOROMIC, 2017 International Microinsurance Conference).
- 2.15 In addition, as with all MIF projects in the microinsurance agenda, this project will have access to the knowledge portal of the International Labor Organization (ILO), and will be generating "Emerging Insights" (easy to read and assimilate knowledge bites), as well as Learning Journals and Learning Events, using the methodology implemented by the MIF based on the experience of the ILO's Microinsurance Innovation Facility. To disseminate the knowledge, the documentation will be published on the website of the project's executing agency, participating health centers, the MIF, the insurance company, and the ILO.

D. Project governance and implementation mechanism

- 2.16 The PROCOSI network will lead project implementation. Because of the number of agencies involved (CRECER, four health centers, and an insurance company), an ad hoc project coordinating committee will be created under the direct leadership of the PROCOSI network's senior manager. The agencies interested in implementing the project (CRECER, PROSALUD, CIES, CEMSE, CSRA, and the Alianza insurance group) will participate on the project coordinating

committee. The latter will receive advisory support from an international consultant who will support project execution and be an active participant in the coordinating committee, with a voice but no vote. The project coordinating committee will serve as an advisory body for the operational and strategic decisions needed for project execution. All meetings of the committee are to be documented and such information will be sent to the MIF in the semiannual project status reports (PSR). The specific functions of the coordinating committee are spelled out in the Operating Regulations.

- 2.17 An executing unit will be established within PROCOSI, with a coordinator and an administrative-accounting assistant, who will create the structure needed to effectively and efficiently conduct project activities and manage its resources. PROCOSI will also be responsible for submitting the progress reports on project implementation. The structure of the executing unit and the progress reporting requirements are detailed in the Operating Regulations (Annex X of this operation's technical files).

E. Sustainability

- 2.18 Once the project has been completed, the product's operation has been systematized, and the executing agency and participating parties have gained the technical know-how to implement the insurance financial product for poor and low-income people, the product is expected to be consolidated in Bolivia's microfinance market and offered by other microfinance institutions in the country. In principle, the idea is that the product will be offered to the other member institutions of FINRURAL, which together have more than 300,000 additional clients who could acquire health microinsurance.²⁴
- 2.19 One year before project execution ends, a Sustainability Workshop will be held with all participating agencies to identify the actions needed to ensure the continuity of project actions once funds have been exhausted.

F. Lessons learned from the MIF and other institutions for project design

- 2.20 Even though the MIF approved a prepaid medical service project in 2013 to benefit the poor population of Haiti, project execution has not yet begun and therefore no experience has been gained or lessons learned regarding the development and design of health microinsurance. This notwithstanding, the MIF can benefit from lessons documented by the ILO. In addition to the difficulty of designing health microinsurance, the most important lessons include: (i) low rates of purchase, (ii) high incidence of claims, and (iii) low rates of renewal. The low rates of purchase and renewal are attributed to a lack of familiarity with insurance and with the use of household strategies for managing risk. This usually happens because the products offered do not reflect potential clients' real needs, both in

²⁴ It is important to note that, for the product to be sustainable, its design must take into account beneficiaries' needs and ability to pay.

terms of health care and in terms of ability to pay and payment methods. These findings will be taken into account in the design of the product.

G. Additionality of the MIF

- 2.21 Nonfinancial additionality. In developing health microinsurance, the challenge is to design structured products that cover high frequency needs at prices appropriate for the target market, while also ensuring that the model is sustainable. The MIF will contribute knowledge on the microinsurance industry and facilitate partnerships with national and international experts. The MIF's reputation provides legitimacy and strengthens the business model, a factor that is expected to arouse the interest of the insurance industry.
- 2.22 Financial additionality. The MIF is one of the few sources of financing for microinsurance programs in the region. In Bolivia, in particular, the Swiss Development Corporation (SDC) is financing a project with PROFIN Foundation. However, the SDC has refocused its activities to target climate change adaptation, with special emphasis on Central America.

H. Project outcomes

- 2.23 Some 60,000 low-income people will benefit from the sale of 20,000 insurance financial products; 60% of the beneficiaries are expected to be women.

I. Project impact

- 2.24 The main impact of the project will be a percentage reduction in out-of-pocket health expenditures by at-risk households that purchase and use health microinsurance. This means that the insured population will be able to maintain a stable household income in a catastrophic health event.²⁵

J. Systemic impact

- 2.25 The microfinance market in Bolivia is one of the largest in the region, with a total of 1.8 million clients. As soon as the product is validated and systematized through the project, a greater number of microfinance institutions in Bolivia and other Latin American and Caribbean countries will be able to develop and include it among the financial products and services they offer their clients, thereby increasing the number of poor and low-income people with access to a health insurance financial product.

III. MONITORING AND EVALUATION STRATEGY

- 3.1 **Baseline.** The methodology already developed by CIES²⁶ will be adopted and implemented as the project baseline. The study will serve as the project baseline and will facilitate, with rigorous monitoring, the evaluation of the social and

²⁵ As mentioned earlier, if a health expenditure is equal to or greater than 10% of a household's monthly income, the expenditure is considered a catastrophic event for low-income households.

²⁶ The vulnerability analysis developed by CIES will be implemented.

economic-financial information on project beneficiaries before, during, and after project execution. The main indicators to be established are: gender, income level, household expenditures broken down by category (housing, food, clothing, health, transportation, etc.), economic activity, marital status, city and municipio of origin, and number of economic dependents. This baseline information, combined with the monitoring and control system developed under Component I, should facilitate the measurement of reductions in out-of-pocket health expenditures by households that purchase and use the health insurance financial product. In other words, it will make it possible to quantify how much its use contributes to normalizing the financial flow of poor and low-income households in the event of unexpected health expenditures.

- 3.2 **Monitoring.** As part of Component I, the project will finance the implementation of a monitoring system and baseline indicators for the project, which will be used to monitor project indicators. The project coordinator will be responsible for project monitoring and for reporting semiannually to the MIF on the progress of the project.
- 3.3 **Midterm evaluation:** An individual consultant will be hired to evaluate the project 18 months into the execution period, or when 50% of the MIF resources have been disbursed, whichever occurs first. This evaluation will examine: (i) the degree of attainment of milestones and objectives set out in the logical framework, as well as the project's response to the problems originally identified; (ii) any significant variation that may have occurred in executing activities, that is, the progress made to introduce the new insurance product; (iii) the degree of efficiency and effectiveness of the health centers and networks participating in the project; and (iv) alternatives and strategies to help strengthen execution and thereby increase the likelihood of achieving the project's expected outcomes. The evaluator will examine in detail the implementation process, the procurement of services, the efficiency of the executing agency and its associates, and the attainment of output indicators and expected outcomes. If deemed appropriate, the evaluation may propose recommendations to ensure the satisfactory conclusion of the project.
- 3.4 **Final evaluation:** The final evaluation of the project will be performed when the implementation period has come to an end. It will include analysis of the outcomes obtained relative to the baseline and the objectives set out in the logical framework. Its focus will be on measuring outcomes related to the implementation of health microinsurance at the institutional and beneficiary levels. **At the institutional level,** the evaluation will examine: the *financial outcomes* of the product implemented (renewal rates, return, financial costs, claim rates, etc.); operational outcomes (staff training at the health centers, development finance institutions, and other distribution channels, system efficiency, costs associated with administering the product, processes, etc.). It will also examine *organizational outcomes* (changes in institutional culture resulting from opening up to new markets and attracting new clients, changes in operational structure,

etc.). **At the client level**, the evaluation should provide information on the degree of user satisfaction, gathered through quantitative and qualitative data analysis and collection methodologies (surveys, focus groups, in-depth interviews, etc.).

- 3.5 **Closing workshop.** In due course, the executing agency, together with other participating agencies, will hold a Closing Workshop to evaluate project outcomes, identify additional tasks required to ensure the sustainability of the actions initiated by the project, and identify and disseminate lessons learned and best practices.

IV. COST AND FINANCING

- 4.1 The total cost of the project is US\$1,308,340, of which US\$900,000 (69.97%) will be contributed by the MIF and US\$408,340 (31.29%) by the counterpart. The execution period will be 42 months and the disbursement period, 48 months.

Component/Description	MIF	Counterpart	Total
C 1 Design of a prepaid health care and health microinsurance model	222,000	106,100	328,100
C 2 Implementation and strengthening of microinsurance management	320,660	203,640	524,300
C 3 Consumer protection and financial education	75,500	33,500	109,000
C 4 Knowledge development and implementation of a communication strategy	48,500	0	48,500
Subtotal execution: components and supervision	666,660	343,240	1,009,900
Executing agency/administrative costs	124,000	65,100	189,100
Midterm evaluation	10,000		10,000
Final evaluation	10,000		10,000
Ex post reviews	7,000		7,000
Contingencies	11,690		11,690
Subtotal	829,350	408,340	1,237,690
Percentage of financing	68%	32%	100%
Impact evaluation account (5%)	43,650		43,650
Total with impact evaluation	873,000	408,340	1,281,340
Institutional strengthening	7,000		7,000
Agenda account	20,000		20,000
Grand Total	900,000	408,340	1,308,340
	68.97%	31.29%	100%

V. EXECUTING AGENCY

- 5.1 The Comprehensive Health Coordination Program (PROCOSI) will be the executing agency for this project and will sign the agreement with the Bank.

PROCOSI is a nongovernmental organization (NGO) active in the nine departments of Bolivia. It is composed of 31 national and international member organizations, which makes it the largest network of comprehensive health and development NGOs in the country. PROCOSI has implemented 15 projects of national scope and, in so doing, responsibly managed a total of US\$40 million. Its average annual program budget for the last four years has been US\$4.3 million, 70% from external funding sources, including the European Union, CAF, and the Bill and Melinda Gates Foundation. The remaining 30% of the budget is financed with own funds, from a trust that ensures the sustainability of actions to strengthen the NGOs that belong to the network.

VI. PROJECT RISKS

- 6.1 **Risks:** The project's most significant risk is the limited knowledge and trust among the beneficiary population and health care providers regarding the insurance sector and the benefits of insurance. Because the insurance sector has essentially been absent from the market segment the project will serve, the project stakeholders are uncertain about the benefits of including a health policy among the services they currently offer. Mitigating factor: To mitigate this risk, the project will provide substantial training at all levels, and the product itself will help overcome the mistrust toward insurance. The staff of participating agencies will receive training on insurance and beneficiaries will be exposed to insurance-related consumer protection issues and financial education. Moreover, the insurance financial product has implicit value given the possibility of receiving services in the short term; this is expected to generate wider acceptance for insurance as a whole.
- 6.2 There is a risk that the product will not achieve the critical mass of beneficiaries needed to make insurance a sustainable financial product; in addition, there is the risk of a very low percentage of renewal. Mitigating factor: This risk will be managed by offering the product to the other member institutions of FINRURAL, which together cover more than 300,000 clients, and to current clients of the health centers, who total more than one million.

VII. ENVIRONMENTAL AND SOCIAL IMPACTS

- 7.1 The project was submitted to the environmental and social review process, approved, and classified as a category "C" operation.

VIII. ATTAINMENT OF MILESTONES AND SPECIAL FIDUCIARY ARRANGEMENTS

- 8.1 Disbursements by results and fiduciary arrangements. The executing agency will agree to the MIF's standard arrangements for disbursements by results, procurement, and financial management, as specified in Annex VIII.

IX. ACCESS TO INFORMATION AND INTELLECTUAL PROPERTY

- 9.1 **Access to information.** This document does not contain confidential information relating to one or more of the ten exceptions of the Bank's Access to Information Policy, and may therefore be disseminated outside the Bank.
- 9.2 **Intellectual property.** All the knowledge and communication products, as well as other materials produced during the project, are the property of the IDB/MIF. Nevertheless, the executing agency may request authorization to use and disseminate these products in view of its commitment to make them available to the public and to promote the transfer of knowledge to other interested institutions.